

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8182

STATE FILE NUMBER

63-033538

FILED AUG 22 1963

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

ST LOUIS,

Length of stay in 1b

c. CITY

ST LOUIS,

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

5037 DURANT AVE

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

5037 DURANT

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

CATHERINE C CORRIGAN

4. DATE OF DEATH

Month

Day

Year

AUG. 11, 1963

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. Married ☐ Never Married ☒

Widowed ☐ Divorced ☐

8. DATE OF BIRTH

1/26/91

9. AGE (last birthday)

72

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HR

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

AT HOME

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

ST LOUIS MISSOURI

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

PATRICK CORRIGAN

13b. MOTHER'S MAIDEN NAME

CATHERINE DYER

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

MARGARET CORRIGAN 5037 DURANT AVE

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐

NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from June 1957 to Aug 1963 and last saw her alive on 8/8/63. Death occurred at 6:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(In three or title)

22b. ADDRESS

22c. DATE SIGNED

Robert Potashnick M.D.

3720 Washington

8/12/63

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE

8/14/63

23c. NAME OF CEMETERY OR CREMATORY

CALVARY CEMETERY

23d. LOCATION (City, town, or county)

ST LOUIS MISSOURI

24. FUNERAL DIRECTOR

ADDRESS

STROOT - CARROLL 4600 NATURAL BRIDGE

25. DATE RECD. BY LOCAL REG.

AUG 12 1963

26. REGISTRAR'S SIGNATURE

Earl Smith. M.D.

USE BLACK INK

OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Dr. Potashnick
Braumont Bldg
ge 19695
11 till 5*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed M W. Rueter

Licensed Embalmer No. 4865

P. O. Address St Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.